MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03516

3532 Item 9, Film c180 4-25-55 at

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) Since 11/2/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 27 Harman Avenue

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Hillary (Last) AHALT

4. DATE OF DEATH: (Month) April (Day) 15 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: January 31, 1883

9. AGE last birthday 72 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timekeeper

10B. KIND OF BUSINESS OR INDUSTRY: ----Unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D. Ahalt

14. MOTHER'S MAIDEN NAME: Harriet Willard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42.0.1

IMMEDIATE CAUSE (A) Coronary occlusion — minutes

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis with hypertension — more than 1½ years

DUE TO

(C) ---

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. — more than 1½ years

19A. DATE OF OPERATION: -----

19B. MAJOR FINDINGS OF OPERATION -----

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -----

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) -----

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. -----

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ -----

21F. HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from 12/7/53, to 4/14/55 that I last saw the deceased alive on April 14, 1955, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. ADDRESS Martin Gross M.D. Sykesville, Md. DATE SIGNED 4/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF APRIL 19-55 — NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETRY — LOCATION (City, town, or county) (State) HAGERSTOWN Md

DATE REC'D BY LOCAL REGISTRAR April 16, 1955 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR C M SOLER SONS — ADDRESS HAG. Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03517

3533

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (or give nearest town) Westminster — LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Westminster Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge — X
STREET ADDRESS (If rural, give location) Broadway — X

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) CLAUDE (Last) BILLMYER

4. DATE OF DEATH: (Month) (Day) (Year) April 28 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: Aug 25-1873

9. AGE last birthday: 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Station Agent

10b. KIND OF BUSINESS OR INDUSTRY: W M R R

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Keener Billmyer

14. MOTHER'S MAIDEN NAME: Caroline Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service) None

16. SOCIAL SECURITY NO.: 705-10-5149

17. INFORMANT & ADDRESS: James I Billmyer, 39 W 67th St New York City NY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arterio sclerotic C-V disease — year.

DUE TO

(c)

422.1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June ..., 19..., to April 28 ..., 19..., that I last saw the deceased alive on April 29 ..., 19..., and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) James I. Marsh M. D. — ADDRESS Westminster Md — DATE SIGNED Apr 28/1955

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF April 30-1955 — NAME OF CEMETERY OR CREMATORY Mt Pleasant — LOCATION (City, town, or county) (State) Union Bridge

DATE REC'D BY LOCAL REG. April 29, 1955 — REGISTRAR'S SIGNATURE Francis M. Gough

24. FUNERAL DIRECTOR D D Hartzler & Sons — ADDRESS New Windsor Md

03518

3534

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (In this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARTHA - (Middle) NORMA (Last) CARR

4. DATE OF DEATH: (Month) April (Day) 12 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: Aug 8-1876

9. AGE last birthday: 78 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Work.

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Basil Gardner

14. MOTHER'S MAIDEN NAME: Rachel Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT AND ADDRESS: Mrs Geo Leppy - Manchester Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Arteriosclerotic Heart Disease	5 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Congestive Heart Failure	1 day
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to April 12, 1955, that I last saw the deceased alive on April 12, 1955, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. H. Foard	M.D.	Manchester Md	4-12-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 15/55	Bucklerville	Balto Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr 12-55	Mrs. W.P. Penner	Edw Clipton	Hampstead Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3535

03519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithers
LENGTH OF STAY (In this place) 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Gaithers
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Ellen (Last) Cooper

4. DATE OF DEATH (Month) April (Day) 26 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F.	W	Married	Sept. 8, 1929	25 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	New York	U.S.A.

13. FATHER'S NAME: Gilbert Hudgins

14. MOTHER'S MAIDEN NAME: Elizabeth R. Ray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	—	Unk.	Charles C. Cooper - Gaithers, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

900.0
Immediate cause (a) Fractured Skull — DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Fall down stairway — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 30 min.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Home	21c. (City or town) Gaithers	(County) Carroll	(State) Md

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
4/26/55 1:45 P.M.		Fell down stairway

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Sharrah M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 4/26/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	4-29-55	Lorraine Park	Baltimore 7, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 27, 1955	C. Harry Weer	Luther H. Height	Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

03520

MARYLAND STATE DEPARTMENT OF HEALTH

3536

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown | LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 70

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wirt	Patterson	Crapster	April 8, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Male	White	Single	Feb. 1, 1926	29 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	none	Maryland	U.S.A.

13. FATHER'S NAME: Walter Crapster
14. MOTHER'S MAIDEN NAME: Ellen Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes	WW2	none	Mr. Walter Crapster, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
974X Immediate cause (a)	Strangulation	Few Min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Suicide by Hanging	
(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Manic Depressive Psychosis — 8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Home	Taneytown	Carroll	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☑	HOW DID INJURY occur?
April 8, 1955 10 a.m.		Hanged self by rope to rafter.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. S. McVaugh	M.D.	Taneytown, Md.	April 8, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 11, 1955	Reformed Cemetery	Taneytown, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
April 9, 1955	Ethel M Mehring	C.O.Fuss & Son, Taneytown, Maryland

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03521

3537

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X LINWOOD
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linwood X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) A (Last) CRUMBACKER

4. DATE OF DEATH: (Month) APRIL (Day) 2 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Aug 14 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Purina Feeds

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Crumbacker

14. MOTHER'S MAIDEN NAME: Ella Koons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: 497-01-1000

17. INFORMANT & ADDRESS: Emma Crumbacker Linwood Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

153 X

Immediate cause (a) DUE TO Carcinoma of liver & Intestine

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1954, to April 2, 1955, that I last saw the deceased alive on 4-2, 1955, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. N Legg M D Union Bridge 4-2-55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial April 5-1955 Lutheran Uniontown Md

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
April 4, 1955 Margaret R. England D D Hartzler & Sons New Windsor Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

3538

2411 N. Charles Street, Baltimore

03522

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Mt. Airy LENGTH OF STAY (in this place) 7 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Mt. Airy X STREET ADDRESS (If rural, give location) Route 2 - Newport Hill
HOSPITAL OR INSTITUTION OR STREET ADDRESS OD Newport Hill - Rt 2	

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Simon	—	Davis	April	6	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	white	Widowed	March 11, 1869	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truckman	Railroad	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bunion Davis	?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No.	—	Mrs. Sam Davis - Route 2 - Mt. Airy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause	(a) Generalized Arteriosclerosis	several years
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July, 1952, to April, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 1:40 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W.B. Culwell	M.D.	Mt. Airy, Md.	April 6, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-9-1955	Mt. Olive	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-8-1955	Robert R. Hewitt, Dpty.	C.M. Waltz	Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03523

3539

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, Film C180 4-29-55 et

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (in this place): 3yrs.12days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City 3V01-4
STREET ADDRESS (If rural give location): 800 Cator Ave. Armacost Nursing Home ✓

3. NAME OF DECEASED (Type or Print): (First) AGNES (Middle) PLACIDE (Last) DEAN
4. DATE OF DEATH: (Month) April (Day) 20 (Year) 19 55
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Unknown
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Doory
14. MOTHER'S MAIDEN NAME: Anna Conley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
585X Immediate cause	(a)	Inflammation of the Pancreas	About 4 wks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying caose last.	DUE TO (b)	Cholecystitis, chronic	Unknown
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — Approx. 8 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-15, 1955, to 4-20, 19 55, that I last saw the deceased alive on 4-20, 1955, and that death occurred at 10:03 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title): Walther H. Sonnenfeldt M.D.
ADDRESS: Springfield State Hospital
DATE SIGNED: April 20, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: 4/22/55
NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL CEM.
LOCATION (City, town, or county) (State): BALTO. MD
DATE REC'D BY LOCAL REGISTRAR: 4-21-55
REGISTRAR'S SIGNATURE: a w Bedwell
24. FUNERAL DIRECTOR: JOHN A. MORAN
ADDRESS: 3000 E. BALTO. ST

WS Re Returns

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03524

3540 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield, Maryland 19-39-2
STREET ADDRESS (If rural give location) 129 S. 4th Street

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Ann (Last) Dix

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-14-1918

9. AGE Last birthday: 37 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Crab Picker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Somerset County, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Harry Sample

14. MOTHER'S MAIDEN NAME: Moreal Collins

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Howard Dix - 129 S. 4th Street, Crisfield, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Far advanced bilateral pulmonary TB, cavitation — Interval Between Onset And Death: October '54

002X

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 1955, to 4-13-, 1955, that I last saw the deceased alive on 4-13-55, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) T F Vestal M D ADDRESS Henryton, Maryland DATE SIGNED 4-13-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Apr 18 1955 NAME OF CEMETERY OR CREMATORY Lawsonia LOCATION (City, town, or county) (State) Garfield Somerset Co Md

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE Albert R Swankhaus

24. FUNERAL DIRECTOR Charles H Conrad Hanover Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3541 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03525

CERTIFICATE OF DEATH

Item 8, FilmG181 5-9-55 et

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll | MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Westminster | LENGTH OF STAY (in this place) 87 | HOSPITAL OR INSTITUTION OR STREET ADDRESS (Rural) RFD - 4

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster (Rural) X | STREET ADDRESS (If rural give location) R F D. 4

3. NAME OF DECEASED: (Type or Print) (First) Agnes (Middle) Virginia (Last) Bull

4. DATE OF DEATH: (Month) April (Day) 18 (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH: June 16 - 1867 | 9. AGE last birthday: 87 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: Own Home | 11. BIRTHPLACE (State or foreign country): - Carroll Co. Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Coats | 14. MOTHER'S MAIDEN NAME: Liddie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: Wilbur Bull Westminster Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 Immediate cause	(a) Arteriosclerotic Heart Disease	5 yrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arteriosclerosis	5 yrs
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 26, 1955, to April 18, 1955, that I last saw the deceased alive on April 17, 1955, and that death occurred at 6:40 AM from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. H. Howard	M. D.	Manchester Md	4-18-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 21, 1955	Westminster Cemetery	Westminster Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-18-55	Hamit Miller	John R. Byers	Westminster, Md.

VS. A15

03526

MARYLAND STATE DEPARTMENT OF HEALTH

3542

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY CARROLL — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X SYKESVILLE — LENGTH OF STAY (in this place) 4½ mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 LIBERTY ROAD - ROUTE 2

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN COLST = SYKESVILLE X
STREET ADDRESS (If rural, give location) ROUTE #3

3. NAME OF DECEASED (Type or Print): (First) MINNIE (Middle) ANN (Last) GRIFFITH
4. DATE OF DEATH: (Month) APRIL (Day) 28 (Year) 1955
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: DEC. 18-1901
9. AGE last birthday: 53 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): TASWELL - VA.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM COLE
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: MR HOWARD GRIFFITH - ROUTE #2 SYKESVILLE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

181X Immediate cause (a) CARCINOMA OF BLADDER C

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) METASTASIS TO LUMBAR VERTEBRA — 3 YEARS
(c) HYPERTENSIVE - C.V. DISEASE - MODERATE — 5 YEARS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from FEB. 1, 19 55, to APRIL 28, 19 55, that I last saw the deceased alive on APRIL 28, 19 55, and that death occurred at 6:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Thomas E. Wheeler MD — 3601 Clipper Rd - Baltimore Md - 4-28-55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: 4-30-1955 | NAME OF CEMETERY OR CREMATORY: Wesley Freedom | LOCATION (City, town, or county) (State): Carroll Co. Md.

DATE REC'D BY LOCAL REG.: APR. 30, 1955 | REGISTRAR'S SIGNATURE: Edith M. Hecott

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield. Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03527

CERTIFICATE OF DEATH

3543 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): X Henryton
LENGTH OF STAY (in this place): 38 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bel Alton, Maryland 08X-2
STREET ADDRESS (If rural give location): ✓

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) (Last) Hawkins

4. DATE OF DEATH: (Month) 4 (Day) 20 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 1871

9. AGE last birthday: 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Handy Man

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William Hawkins

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT & ADDRESS: Mary Sweete - Bel Alton, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

002X
Immediate cause (a) Far advanced bilateral pulmonary tuberculosis — Dec. 1954

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-13-, 1955, to 4-20-, 1955, that I last saw the deceased alive on 4-20-, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): T. F. Hodal M.D — ADDRESS: Henryton, Maryland — DATE SIGNED: 4-20-55

23. BURIAL, CREMATION, REMOVAL: (Specify) Burial — DATE THEREOF 4/23/55 — NAME OF CEMETERY OR CREMATORY: St Ignatius — LOCATION (City, town, or county) (State): Chapel Point md

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE: Albert A. Swankhouse

24. FUNERAL DIRECTOR — ADDRESS: Orchart Funeral Home Laplata md

03528

3528

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (In this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 58 E. Main

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 58 E. Main

3. NAME OF DECEASED (Type or Print): (First) ESTELLA (Middle) S. (Last) HOFFE

4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1955

5. SEX: F — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced — 8. DATE OF BIRTH: June 5-1902 — 9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Wilcox Co. Georgia — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Lumford Roland — 14. MOTHER'S MAIDEN NAME: Mary Frances Jordan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no — 16. SOCIAL SECURITY NO.: 254-24-8911 — 17. INFORMANT: Charles J. Elkins Humbert apts. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary occlusion — Interval between onset and death: Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C V disease — years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED

James T. Moore — Deputy Med. Examiner — Westminster Md — 4/9/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: April 12, 1955 — NAME OF CEMETERY OR CREMATORY: Pleasant Hill Cemetery — LOCATION (City, town, or county) (State): Sycamore Georgia

DATE REC'D BY LOCAL REG. 4-9-55 — REGISTRAR'S SIGNATURE: Hamilton Mullen — 24. FUNERAL DIRECTOR — ADDRESS: Bankard & Son Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03529

CERTIFICATE OF DEATH

3544

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Rural Westminster
LENGTH OF STAY (in this place) 85 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. 4

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Mln.
HENRY LEWIS HOSFELD	April 4 1955	M	W	Married	Dec. 25 1869	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer	own Farm	Md.	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George A. Hosfeld	Mary Mahaley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Mrs Cora Hosfeld R.D. 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
442X Immediate cause	(a) Acute Cardiac Decompensation	4 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Cardio-Renal Vascular disease	5 yrs
	DUE TO (c) Arteriosclerosis	6 yrs
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	Carcinoma Prostate	5 yrs

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from April 4, 1955 to April 4, 1955, that I last saw the deceased alive on April 4, 1955, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE Chas K Fonts (DEGREE OR TITLE) MD ADDRESS Westminster Md DATE SIGNED 4-5-55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 6 1955	Deister Cemetery	Westminster Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-6-55	Hamil T Miller	A Bankard & Son	Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03530

3529

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 127 E. Green St. 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural give location) 127 E. Green St.

3. NAME OF DECEASED: (Type or Print) (First) Joshua (Middle) Leland (Last) Jordan

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 20, 1897

9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Westminster, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Scott I. Jordan

14. MOTHER'S MAIDEN NAME: Henerietta Boring

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W W 1

16. SOCIAL SECURITY No.: 212-01-8693

17. INFORMANT & ADDRESS: Margaret B. Jordan Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Thrombosis — Interval Between Onset And Death: Few minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertension Coronary Sclerosis & Angina — Dec 1954

DUE TO (c) Cerebral Hemorrhage — March 1955

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1954, to April 22, 1955, that I last saw the deceased alive on April 22, 1955, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wilene Belcher ADDRESS Westminster Md DATE SIGNED 4-23-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Apr. 25, 1955 NAME OF CEMETERY OR CREMATORY Westminster Cemetery LOCATION (City, town, or county) (State) Westminster Maryland

DATE REC'D BY LOCAL REGISTRAR April 23, 1955 REGISTRAR'S SIGNATURE Lorine M. Gough

24. FUNERAL DIRECTOR ADDRESS John R. Byers Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03531

3545

CERTIFICATE OF DEATH

Reg. Dist. No. 7X

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 16yrs.4days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 2312 E. Fayette Street

3. NAME OF DECEASED: (Type or Print) (First) RAYMOND (Middle) LOUIS (Last) KANE

4. DATE OF DEATH: (Month) April (Day) 22 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: Nov. 25, 1892
9. AGE last birthday 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: E. J. Codd
11. BIRTHPLACE (State or foreign country): Maryland, Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael T. Kane
14. MOTHER'S MAIDEN NAME: Mary A. Flaharty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

0024

IMMEDIATE CAUSE (A) Tuberculosis of lung, far-advanced — Unknown

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia — 33 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8-, 1955, to 4-22, 1955, that I last saw the deceased alive on 4-22, 1955, and that death occurred at 12:10 PM, from the causes and on the date stated above.

SIGNATURE Walter H. Sommerfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 4-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Apr. 26, 1955
NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 4-25-55
REGISTRAR'S SIGNATURE H. W. Nedrow
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural, give location) Route 3 Wolfe Rock Rd.

3. NAME OF DECEASED: (Type or Print) (First) Mildred (Middle) M. E. (Last) Leach Kelly

4. DATE OF DEATH (Month) April (Day) 15 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 8-28-11

9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Claude Leach

14. MOTHER'S MAIDEN NAME: Rebecca Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Hanging by the neck — Interval between onset and death:

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. psychotic depressive reaction

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY S's Hospital

21c. (City or town) Sykesville (County) Carroll (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Marsh M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 4/15/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 4-19-55

NAME OF CEMETERY OR CREMATORY Mt Hope

LOCATION (City, town, or county) Woodbine, Md. (State)

DATE REC'D BY LOCAL REG. April 17, 1955

REGISTRAR'S SIGNATURE C. Harry Tilden

24. FUNERAL DIRECTOR Luther N. Haught ADDRESS Sykesville, Md.

03533

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3547

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester
STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print): (First) FLORENCE (Middle) CONSTANCE (Last) LAUER

4. DATE OF DEATH (Month) (Day) (Year): April 2, 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: NOVEMBER 16, 1878

9. AGE last birthday: 76 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE MARYLAND.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? CONSTANCE

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: 3028 KENYON AVE. MR HARRY L. CLEAVER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 1 hour

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — 15 yrs

(c) Arteriosclerosis — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to April 2, 1955, that I last saw the deceased alive on 3-24, 1955, and that death occurred at 10:50 a.m., from the causes and on the date stated above.

SIGNATURE: M.C. Porterfield — (Degree or title): M.D — ADDRESS: Hampstead Md — DATE SIGNED: 4/2/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: APRIL 5, 1955 — NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: 4-5-55 — REGISTRAR'S SIGNATURE: C. W. Hedrick

24. FUNERAL DIRECTOR: H. SANDER & SONS, INC. — ADDRESS: Baltimore, Maryland — George Sander

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03534

3548

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville

LENGTH OF STAY (in this place): 28 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Myersville 10 X -2

STREET ADDRESS (If rural give location): Route # 2 ✓

3. NAME OF DECEASED: (Type or Print) (First) IRA (Middle) ELLSWORTH (Last) LEWIS

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 5-16-74

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lewis

14. MOTHER'S MAIDEN NAME: Elizabeth Harrison

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

693.4

Immediate cause (a) Myocardial Infarction — Interval Between Onset And Death: Hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cellulitis with lymphangitis of leg — 3 weeks

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain dis., with psychotic reaction. — About 5 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-5-, 19 55, to 4-26, 19 55, that I last saw the deceased alive on 4-26, 19 55 and that death occurred at 10:40 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): Edmund Rusthan — ADDRESS: Springfield State Hospital — DATE SIGNED: 4-26-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 4-29-55 — NAME OF CEMETERY OR CREMATORY: Mt. Bethel — LOCATION (City, town, or county) (State): Garfield, Md.

DATE REC'D BY LOCAL REGISTRAR: April 29, 1955 — REGISTRAR'S SIGNATURE: C. Harry Allen

24. FUNERAL DIRECTOR — ADDRESS: Gladhill Co. Middletown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03535

3530

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: 27 Westminster

LENGTH OF STAY (in this place): 20 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00 101 John St. x

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 27

STREET ADDRESS (If rural give location): 101 John St. 1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Mary	----	Locascio	April	5	19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	Feb. 14, 1880	75 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Italy	Italy V

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Victor Gaglianno	Liboria Purporia

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no - - - - -	- - - - - - -	Vincent Locascio Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Uremic Coma	2 days
DUE TO		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Cardio-renal-vascular disease	3 years
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
no	—	—	—	—

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
none m.		—

22. I hereby certify that I attended the deceased from April 15, 1946, to 4-5, 1955, that I last saw the deceased alive on 4-5, 1955, and that death occurred at 12:15 P. M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Billingslea	M.D	Westminster, Md.	4-6-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Apr. 8, 1955	St. John's Catholic	Westminster	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-6-55	Harriet Miller	John R. Byers	Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03536

3549

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 3y10m20days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) 618 Chestnut Hill Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) Amelia (Middle) Susan (Last) Maglidt

4. DATE OF DEATH: (Month) 4 (Day) 9 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 5 - 1 - 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pensylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Heilman

14. MOTHER'S MAIDEN NAME: Amelia Sauter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn.

17. INFORMANT & ADDRESS: William Maglidt, 618 Chestnut Hill ave. Balto.18.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X

IMMEDIATE CAUSE (A) Cerebral hemorrhage — 2 weeks

DUE TO

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive cardiovascular disease — years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chron.brain syndrome assoc.with senile disease with psychotic reactions — years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8-, 1955 to 4-9-, 1955 that I last saw the deceased alive on 4-9-, 1955, and that death occurred at 5:55 P M, from the causes and on the date stated above.

SIGNATURE Edmund J. Lusthaus M. D. ADDRESS Springfield State Hospital DATE SIGNED 4-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Apl 12-55 — NAME OF CEMETERY OR CREMATORY Greenmount — LOCATION (City, town, or county) York (State) Penna

DATE REC'D BY LOCAL REGISTRAR 4-11-55 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Bertrand [illegible] — ADDRESS 2224 [illegible]

3550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 035374

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) since 5/15/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 1535 E. Baltimore Street

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) R. (Last) Manly

4. DATE OF DEATH: (Month) Apr. (Day) 22 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: 8-25-90

9. AGE last birthday 64 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): odd jobs

10B. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Manley

14. MOTHER'S MAIDEN NAME: Rose Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes-Navy (If Yes, give war or dates of service) 4-14-17/5-6-20

16. SOCIAL SECURITY NO. 219-03-9677

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

491 X

IMMEDIATE CAUSE (A) Bronchopneumonia — 18 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with alcohol intoxication, with psychotic reaction — about 4 years

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. —

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 5-15-53, 19__, to 4-22-, 19 55 that I last saw the deceased alive on 4-22-, 1955, and that death occurred at 11.35 PpM, from the causes and on the date stated above.

SIGNATURE Florian Nadolski M. D. ADDRESS Sykesville, Md DATE SIGNED April 23, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Apr 26/55 NAME OF CEMETERY OR CREMATORY Parkwood Mem LOCATION (City, town, or county) Baltimore (State)

DATE REC'D BY LOCAL REGISTRAR 4-25-55 REGISTRAR'S SIGNATURE R. W. Gabriel Deputy

24. FUNERAL DIRECTOR Phelps Downey Sons ADDRESS 2024 Eutaw St

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0353

1 3551

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 7 yrs. 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 W 01-4
STREET ADDRESS (If rural give location) Helping Hand Mission ✓

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) COGAN (Last) MARTIN

4. DATE OF DEATH: (Month) April (Day) 5, (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 3-25-1900
9. AGE last birthday 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer
10B. KIND OF BUSINESS OR INDUSTRY: Masonry
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick F. Martih
14. MOTHER'S MAIDEN NAME: Mary Cogan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) -
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 422.1 (A) Cardio-vascular disease — Interval between onset and death: Years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (322.1) DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic alcoholism with deterioration. Years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-10, 1955, to 4-5-, 1955, that I last saw the deceased alive on 4-5, 1955, and that death occurred at 10:20 AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 4/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 4-9-55
NAME OF CEMETERY OR CREMATORY Elkins
LOCATION (City, town, or county) (State) Elkins W. Va.

DATE REC'D BY LOCAL REGISTRAR April 6, 1955
REGISTRAR'S SIGNATURE C. Henry Lowe
24. FUNERAL DIRECTOR F. E. Runner. ADDRESS Elkins, W. Va.

03539

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3552

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (in this place) 69 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Tannery Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster R.D. #4
STREET ADDRESS (If rural, give location) Old Tannery Road

3. NAME OF DECEASED (Type or Print): (First) LUTHER (Middle) CLEVELAND (Last) MARTIN

4. DATE OF DEATH: (Month) April (Day) 27 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 29, 1885

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker

10b. KIND OF BUSINESS OR INDUSTRY: Piston Ring factory

11. BIRTHPLACE (State or foreign country): Carrollton Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Martin

14. MOTHER'S MAIDEN NAME: Mary A. Sharp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-01-1953

17. INFORMANT AND ADDRESS: Mrs L. Martin, Westminster Md. RD#4

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X

Immediate cause (a) Metastatic Carcinoma to liver — Interval between onset and death: 1 year

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma rectum — 2 years

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec. 4, 1953

19b. MAJOR FINDINGS OF OPERATION: Carcinoma rectum with metastases to liver

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 30, 1953, to April 27, 1955, that I last saw the deceased alive on April 27 55, and that death occurred at 9:52 A m., from the causes and on the date stated above.

SIGNATURE: Julius Chepko — (Degree or title) M.D. — ADDRESS: Westminster Md — DATE SIGNED: 4/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 30/55 — NAME OF CEMETERY OR CREMATORY: Leisters Cemetery — LOCATION (City, town, or county) (State): Rural, Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: April 28, 55 — REGISTRAR'S SIGNATURE: Louise M. Gough

24. FUNERAL DIRECTOR: J. E. Myers Jr. — ADDRESS: Westminster Md.

03540

MARYLAND 3553 **STATE DEPARTMETT OF HEALTH**

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 2, Film G181, 5/12/55 fcy

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville — LENGTH OF STAY (in this place) 5yrs. 8days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City, 417 N. Charles St.
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital, give street address or location) 15 Springfield State Hospital	STREET ADDRESS (If rural, give location) Church Home Hosp. Broadway & Fairmount Ave

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Anna	Rebecca	Mills	4	27	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	9-16-1864	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Seamstress -- Housewife	---	Hidgesville, West Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Startzman	Miranda A. Snodgrass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
---	---	---	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary occlusion	2 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	10 yrs.
	(c) Senile psychosis	10 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
----	-----	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
----	----	----		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
----			m.		----

22. I hereby certify that I attended the deceased from 1-16-, 1952, to 5-27-, 1955, that I last saw the deceased alive on 4-27-, 1955, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE M. N. Mastin, M.D. (Degree or title) — ADDRESS Springfield State Hosp. - Sykesville, Md. — DATE SIGNED 4-27-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-2-55	Mt Carmel	Baltimore

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-2-55	C.W. Hedrick	Fred A. Cole	1913 W. Balto. St.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1 03541

3554

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fcneboro
LENGTH OF STAY (in this place) 28 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md, COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fcneboro
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) (Last) Monath

4. DATE OF DEATH: (Month) April (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: July 31 1862

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Cobbler

10b. KIND OF BUSINESS OR INDUSTRY: Self.

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Monath

14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: E. I. Roath, Linboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause (a) Broncho-Pneumonia — Interval Between Onset And Death: 1 wk

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart — 5 yrs
DUE TO (c) Disease

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7, 1948, to 4-21, 1955, that I last saw the deceased alive on 4/20, 1955, and that death occurred at 10.55 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W H Foard MD Manchester, Md 4-21-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 4/23/55 — NAME OF CEMETERY OR CREMATORY Fcneboro — LOCATION (City, town, or county) (State) Fcneboro Carroll Md

DATE REC'D BY LOCAL REGISTRAR Apr. 22-55 — REGISTRAR'S SIGNATURE Mrs. H. P. Donner

24. FUNERAL DIRECTOR H. C. Seiffert Son — ADDRESS New Park, Pa.
H. C. Seiffert

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03542

3555

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 2month17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City (11) 3X01-4
STREET ADDRESS (If rural give location) 409 Central Avenue ✓

3. NAME OF DECEASED: (Type or Print) (First) JOSEPH (Middle) MICHAEL (Last) MOULDS

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Divorced

8. DATE OF BIRTH: June 29, 1897

9. AGE last birthday 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sail Maker

10B. KIND OF BUSINESS OR INDUSTRY: Robinson Bros.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X

IMMEDIATE CAUSE (A) Cancer of the lung — INTERVAL BETWEEN ONSET AND DEATH: 6 months +

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with new growth, with intra-cranial neoplasm, with psychotic reaction. — About 6 months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION (metastatis - primary Ca. of the lung)

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-11, 1955 to 4-28, 1955, that I last saw the deceased alive on 4-27, 1955, and that death occurred at 3:40AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfelds M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4/30/55

NAME OF CEMETERY OR CREMATORY St.Mary's, Hampden

LOCATION (City, town, or county) (State) 3900 Roland Ave, Md.

DATE REC'D BY LOCAL REGISTRAR April 27, 1955

REGISTRAR'S SIGNATURE A. A. Fredrick

24. FUNERAL DIRECTOR Austin E. Donovan

ADDRESS 3816 Roland Ave

03543

3555

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 26

Item 8, FilmC180 4-26-55 e t

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 59 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Willow Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) 15 Willow Avenue

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH: (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
CHARLES FRANKLIN MYERS	April 16 1955	M	W	Married	1886 - 2 - 18	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Westminster Shoe Co.	Maryland	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Albin D. Myers	Katherine Starner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	218-05-7187	Bertha Myers 15 Willow Avenue Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X
Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 days 3/4

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
				Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Apr. 4, 1955 to April 16, 1955 that I last saw the deceased alive on Apr. 16, 1955, and that death occurred at 10:45 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Abel Petrikovsky M.D. Westminster 4/18/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 19, 1955	Bridge Cemetery	Westminster, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-19-55	Hamit Miller	H. Bankard & Son	Westminster, Md.

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03544

3557

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) New Windsor
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural give location) Main St

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
LEWIS	EDWARD	PATTERSON	APRIL	13	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	C	M	Oct 12-1895	59 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Lewis E Patterson Sr	Mary Bell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	no	212-03-5381	Lydia J Patterson, New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 169X Carcinoma of Lung — Interval Between Onset And Death 1 yr.

DUE TO

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Ca of Left Lung	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1954, to Apr 13, 1955, that I last saw the deceased alive on Apr 12, 1955, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James J Marsh	M.D	Westminster Md	4/15/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4/16/55	Mt Olive	Carroll Co. Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr 15 55	Emma L Bemiller	D D Hartzler & Sons	New Windsor

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND

STATE DEPARTMETT OF HEALTH

03545

3558

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Carroll (Myers District) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural, Union Mills
LENGTH OF STAY (in this place) 2 yrs. 8 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Meadow View Convalescent Home Westminster, Md. R. D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna. COUNTY Adams County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Littlestown
STREET ADDRESS (If rural, give location) East King Street

90 75X-3

3. NAME OF DECEASED (Type or Print): (First) Flora (Middle) Belle (Last) Reindollar

4. DATE OF DEATH: (Month) 4/29/55 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3/1/1865

9. AGE last birthday: 90 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework, Housewife, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Harner

14. MOTHER'S MAIDEN NAME: Rebecca Fink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: J. Ray Reindollar Lumber St., Littlestown, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2

Immediate cause (a) chronic myocardial disease — Interval between onset and death: 10 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1955 to April 30, 1955, that I last saw the deceased alive on April 29, 1955, and that death occurred at 11:55 p m., from the causes and on the date stated above.

SIGNATURE Donald B. Cooper (Degree or title) M. D. ADDRESS Littlestown Pa DATE SIGNED April 30, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 5/2/55

NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery

LOCATION (City, town, or county) (State): Littlestown, Adams Co., Pa.

DATE REC'D BY LOCAL REG. 4-30-55

REGISTRAR'S SIGNATURE Hamit Miller

24. FUNERAL DIRECTOR: J. W. Little & Son Per R. A. Little

ADDRESS: Littlestown, Pa.

MARGIN RESERVED FOR BINDING

03546

MARYLAND

STATE DEPARTMETT OF HEALTH

3559

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 9mos. 19days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3 Vo 1-4
STREET ADDRESS (If rural, give location) 3319 Dudley Ave. ✓

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) (Last) Rezek

4. DATE OF DEATH: (Month) 4 (Day) 13 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-24-1885

9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Czech.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Broz

14. MOTHER'S MAIDEN NAME: Anna (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 X Immediate cause (a) Cerebral hemorrhage — 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION: -----

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ----

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ----

(CITY OR TOWN) -----

(COUNTY)

(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from 1-15-19 55, to 4-13-, 19 55, that I last saw the deceased alive on 4-12-, 19 55, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

SIGNATURE M. N. Mastin, M.D. (Degree or title) — ADDRESS Springfield State Hosp. - Sykesville, Md. — DATE SIGNED 4-13-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE 4-16-55 — NAME OF CEMETERY OR CREMATORY: Oak Hill — LOCATION (City, Town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: April 14, 1955 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: F. Coale — ADDRESS: 900 Chester St. Balto. Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03547

3560

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville,
LENGTH OF STAY (In this place) 42 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City 03X-2
STREET ADDRESS (If rural give location) c/O Ernie Barth, Route 99, Ellicott City

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Keyes (Last) Ridgely

4. DATE OF DEATH: (Month) 4 (Day) 2 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 8 - 11 - 94

9. AGE last birthday 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Gaither

14. MOTHER'S MAIDEN NAME: Mary Keyes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn.

17. INFORMANT & ADDRESS: Ernest Ridgely c/O Ernie Barth, Route 99

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X IMMEDIATE CAUSE (A) Pleural Effusion, both lungs — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cancer of the right breast — 2 years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. C.B.S. ass.with cerebral arteriscleros-is with psychotic reactions — years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-19-, 1955, to 4-1-, 1955, that I last saw the deceased alive on 4-2-, 1955, and that death occurred at 7-2 P.M, from the causes and on the date stated above.

SIGNATURE Edmund Lustbader M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-3-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 4-6-55

NAME OF CEMETERY OR CREMATORY St Johns

LOCATION (City, town, or county) (State) Ellicott City, Md.

DATE REC'D BY LOCAL REGISTRAR April 4, 1955

REGISTRAR'S SIGNATURE C. Harry Likes

24. FUNERAL DIRECTOR Wm McNutt & Son ADDRESS Catonsville

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03548

MARYLAND — **STATE DEPARTMETT OF HEALTH**

3561

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Sykesville
LENGTH OF STAY (In this place): 6mo. 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland 01-02-2
STREET ADDRESS (If rural, give location): 315 Franklin Street ✓

3. NAME OF DECEASED (Type or Print): (First) Marie (Middle) Catherine (Last) Russell

4. DATE OF DEATH: (Month) 4 (Day) 24 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: 2-2-1883

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk-

10b. KIND OF BUSINESS OR INDUSTRY: Unk-

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Alien

13. FATHER'S NAME: Antone Berdollt

14. MOTHER'S MAIDEN NAME: Margaret Muler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk-

17. INFORMANT AND ADDRESS: Anthony J. Russell - Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X
Immediate cause (a) Cerebral hemorrhage — 14 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) HyperteHsive arteriosclerotic cardiovascular disease — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. due to Cerebral arterioscleroticis — several mo.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 19 54, to 4-24, 1955, that I last saw the deceased alive on 4-24, 1955, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walter H. Sonnenfeldt M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: 4/24/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 4/27/55 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cem. | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: 4-25-55 | REGISTRAR'S SIGNATURE: C. Harry Eckert

24. FUNERAL DIRECTOR: John Hofer — ADDRESS: Cumb., Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3531 CERTIFICATE OF DEATH

03549

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Webster Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 14 Webster Street

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) Russell (Last) Schweigart

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 10, 1875

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: City Bldgs.

11. BIRTHPLACE (State or foreign country): Westminster, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Schweigart

14. MOTHER'S MAIDEN NAME: Emily Mourer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ------

16. SOCIAL SECURITY No.: 216-07-2935

17. INFORMANT & ADDRESS: Mrs. Agnes B. Schweigart Westminster, Md

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause	(a) cardio vascular disease	1950
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) arteriosclerosis	about 1945
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	none	

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 15, 1949, to Apr. 28, 1955, that I last saw the deceased alive on Apr. 28, 1955, and that death occurred at 7.45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. Billingslea M.D. ADDRESS Westminster, Md. DATE SIGNED 4-29-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Apr. 30, 1955 NAME OF CEMETERY OR CREMATORY Westminster LOCATION (City, town, or county) (State) Westminster Md.

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE Apr 29 1955 Louise B. Emigh

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03550

3562

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: X Union Mills
LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 90 Meadow View Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural give location): 144 Penna. Ave. 27 1

3. NAME OF DECEASED: (Type or Print) (First) Laura (Middle) Genevieve (Last) Shipley

4. DATE OF DEATH: (Month) April (Day) 23 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 11, 1859

9. AGE last birthday: 96 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Lambert

14. MOTHER'S MAIDEN NAME: Cordelia Ann Glass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY NO.: - - - - - - -

17. INFORMANT & ADDRESS: Miss Lillian Shipley Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 24 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) arteriosclerosis — 10 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to April 23, 1955, that I last saw the deceased alive on April 23, 1955, and that death occurred at 12:35 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Julius Chopko M.D. 130 E. Green Westminster, Md. 4/23/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Apr. 25, 1955 — NAME OF CEMETERY OR CREMATORY: Westminster Cemetery — LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REGISTRAR: April 23. 1955 — REGISTRAR'S SIGNATURE: Louise M. Emrich

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03551

3563

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 5 yr
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY 3 V 01-4
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore Md
STREET ADDRESS (If rural give location) 1629 E Patapsco

3. NAME OF DECEASED: (Type or Print) (First) Ephrina (Middle) (Last) Stepanuk
4. DATE OF DEATH (Month) Apr (Day) 3 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	Sept 15 1892	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Laundry	Russia	Unk.

13. FATHER'S NAME: Mike Kozak
14. MOTHER'S MAIDEN NAME: Olga Kovanch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Unk.		Unk	Oscar Stepanuk

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion — 24 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Fibrillation Arteriosclerosis — 10 yrs

DUE TO (C) Hypertension — 5 yr

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 12, 19 54, to April 3, 19 55, that I last saw the deceased alive on Apr 3, 19 55, and that death occurred at 3-30 P.M. from the causes and on the date stated above.

SIGNATURE M. D. Madison MD ADDRESS Sykesville Md DATE SIGNED April 3 55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buried	4-6-55	Russian Orthodox	Elkridge, Howard, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 4, 1955	C. Harry Weer	John F. Kenny Inc.	915 Light St. Balto.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3564 **CERTIFICATE OF DEATH** 03552

Reg. Dist. No. 56

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. 4 Reese

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
STREET ADDRESS (If rural give location) R. 4 Reese

3. NAME OF DECEASED: (Type or Print) (First) Addie (Middle) Belle (Last) Taylor

4. DATE OF DEATH: (Month) April (Day) 15 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Jan. 25, 1875

9. AGE last birthday: 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frederick County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles T. Blizzard

14. MOTHER'S MAIDEN NAME: Catherine Brown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY No.: - - - - -

17. INFORMANT & ADDRESS: Mrs. Hilda Green R 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 week

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerosis 2nd + Hypertension — 1 year
DUE TO (c) Myocarditis - chronic — years

443X

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-30, to 4-15, 19 55, that I last saw the deceased alive on 4-15, 19 55, and that death occurred at 2 PM from the causes and on the date stated above.
SIGNATURE (Degree or title) James A Saffell MD ADDRESS Reisterstown Md DATE SIGNED 4-15 55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF April 18, 1955
NAME OF CEMETERY OR CREMATORY St. Paul's
LOCATION (City, town, or county) (State) Arcadia Balto Co. Md.

DATE REC'D BY LOCAL REGISTRAR 4-16-55
REGISTRAR'S SIGNATURE Harold Smith

24. FUNERAL DIRECTOR ADDRESS John R. Byers Westminster, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03553

3565

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster R6
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bird Hill

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster R 6
STREET ADDRESS (If rural give location) Bird Hill

3. NAME OF DECEASED: (Type or Print) (First) Martico (Middle) (Last) Welch

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 2, 1867

9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Martico Welch

14. MOTHER'S MAIDEN NAME: Sarah Ann Ogg

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY No.: - - - - - -

17. INFORMANT & ADDRESS: Samuel M. Welch R. 6 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — Interval Between Onset And Death: 10 days.

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerotic Cardiovascular Renal Disease — 7 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/23, 1955, to 4/4, 1955, that I last saw the deceased alive on 4/3, 1955, and that death occurred at 10:5 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Allen Morton M.D. Westminster Md 4/4/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Apr. 6, 1955
NAME OF CEMETERY OR CREMATORY Deer Park Cemetery
LOCATION (City, town, or county) (State) Smallwood, Maryland

DATE REC'D BY LOCAL REGISTRAR 4-5-55
REGISTRAR'S SIGNATURE Harriet Mullen

24. FUNERAL DIRECTOR John R. Byers ADDRESS Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03554

3566

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Manchester
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 104 Park Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester X
STREET ADDRESS (If rural, give location) 104 Park Ave

3. NAME OF DECEASED: (Type or Print) (First) Rudolph (Middle) Belschen (Last) Wink

4. DATE OF DEATH: (Month) 4 (Day) 15 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 11/27/91

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Funeral Director

10b. KIND OF BUSINESS OR INDUSTRY: (own)

11. BIRTHPLACE (State or foreign country): Carroll Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jacob Wink

14. MOTHER'S MAIDEN NAME: Annie Josephine Belschen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Treva B. Wink Manchester Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) adenocarcinoma — 2 yrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Ileum

DUE TO (c) Widespread metatases

152X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1953, to April 15, 1955, that I last saw the deceased alive on 4-13, 1955, and that death occurred at 3 AM, from the causes and on the date stated above.

SIGNATURE W H Howard (Degree or title) MD ADDRESS Manchester Md DATE SIGNED 4-15-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 4/17/55 NAME OF CEMETERY OR CREMATORY Manchester Cem. LOCATION (City, town, or county) (State) Manchester Carroll Md

DATE REC'D BY LOCAL REGISTRAR 4-17-55 REGISTRAR'S SIGNATURE Mrs. H.P.S. Lerner

24. FUNERAL DIRECTOR J. J. Keenan Mt. Sherman Pa ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03555

3567

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural--Westminster

LENGTH OF STAY (in this place): life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Westminster X

STREET ADDRESS (If rural, give location): 1

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) W. (Last) Wolf

4. DATE OF DEATH: (Month) April (Day) 7, (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	widowed	9-20-1877	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
farmer	owner	Maryland	U.S.

13. FATHER'S NAME: Peter Wolf

14. MOTHER'S MAIDEN NAME: Christina ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Peter Wolf, Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

421.4

Immediate cause (a) Chr. Valvular Heart Disease deconpensation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Chronic nephritis (Anuria)

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 4/1/55, to 4/7/55, that I last saw the deceased alive on 4/7/55, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Wm. E. Martin, M.D. Randallstown Md 4/8/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	4-10-1955	Trinity Lutheran	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
4 Apr 55	Harriet Miller	C. M. Waltz, Winfield, Maryland

3563 03556

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural Westminster
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Manchester road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (Type or Print) (First) NINA (Middle) V. G (Last) WOOD
4. DATE OF DEATH (Month) April (Day) 9 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 1868
9. AGE Last birthday: about 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Halifax, Canada
12. CITIZEN OF WHAT COUNTRY? Canada
13. FATHER'S NAME: John Taylor Wood
14. MOTHER'S MAIDEN NAME: Lola Mackubin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Miss Lola Wood College Hill Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Cerebral Hemorrhage — Interval between Onset and Death: Minutes
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Arterio Sclerotic C-V disease — Years
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, ~~Inquiry ☐~~, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J Mann M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED 4/9/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF April 12-1955
NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery
LOCATION (City, town, or county) Westminster (State) Md.
DATE REC'D BY LOCAL REG. 4-11-55
REGISTRAR'S SIGNATURE Harriet Mueller
24. FUNERAL DIRECTOR ADDRESS H Bankard & Son, Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03557

3569

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
MARYLAND
LENGTH OF STAY (in this place) 29yr. 3mo. 24days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland
COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3Y01-4
STREET ADDRESS (If rural give location) 703 N. Gilmor Street ✓

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) WHITRIDGE (Last) WYNN

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 1, 1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph R. Wynn

14. MOTHER'S MAIDEN NAME: Emily Gould

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1
(a) Myocardial infarction — Interval Between Onset And Death: minutes

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Coronary occlusion — Interval Between Onset And Death: hours.
DUE TO
(c) Arteriosclerotic cardio-vascular disease — Interval Between Onset And Death: years.
904.9

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of left hip — 45 days; Manic depressive reaction, manic phase, plus alcoholism. — 39 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1955, to 4-26, 1955, that I last saw the deceased alive on 4-26, 1955, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or Title) Walther H. Sommerfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 4-26-55

23. BURIAL, CREMATION, REMOVAL (Specify) Removal

DATE THEREOF 4-26-55

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) 1217 St Paul St Balto.

DATE REC'D BY LOCAL REGISTRAR April 27, 1955

REGISTRAR'S SIGNATURE C. Harvey Ward

24. FUNERAL DIRECTOR Wm Cook, Inc.

ADDRESS 1217 St Paul St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3570

03558
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 1month9days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY:
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Baltimore 1
STREET ADDRESS (If rural, give location): 721 W. Lexington Street

3. NAME OF DECEASED: (Type or Print) (First) ROSE (Middle) (Last) ZILINSKA

4. DATE OF DEATH (Month) April (Day) 30 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	1-1-1873	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Poland	Unknown

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Martera ?	Agnes Agorta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	—	Unk -	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause (a)	Bronchopneumonia	Hours
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	Cardio-vascular renal disease	Unknown
DUE TO		
(c)	Arteriosclerosis	Unknown

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic react. Unknown

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Hospital	Sykesville	Carroll	Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
4	19	1955	8:50 P.M.			Fell out of bed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: James I. Mahoney M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED: 5/2/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	5-4-55		1217 St Paul St. Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
May 4, 1955	C. Harry Weis	Wm. Cook Inc. 1217 St Paul St Balto Md.